

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

15983

FILED MAY 15 1944

Registration District No. 339

Primary Registration District No. 6149

State File No. _____

Registrar's No. 4

1. PLACE OF DEATH:

(a) County Stoddard
(b) City or town Rural D. Stoddard
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: May
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

3. (a) PRINT FULL NAME Wilson Calvin Steward

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced, Married

6. (b) Name of husband or wife Suda G. Steward 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased November 20 1863
(Month) (Day) (Year)

8. AGE: Years 80 Months 4 Days 11 If less than one day _____ hr. _____ min.

9. Birthplace Puxico Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business Farming

12. Name John Steward

13. Birthplace No Data
(City, town, or county) (State or foreign country)

14. Maiden name Margrett Steward

15. Birthplace no data
(City, town, or county) (State or foreign country)

16. (a) Informant Suda G. Steward
(b) Address Puxico Missouri

17. (a) Burial (b) Date thereof 4 2 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rock Hill

18. (a) Signature of funeral director Watkins Service

(b) Address Puxico Mo.

19. (a) 4-8-1944 (b) Jm Steward
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stoddard
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 31
year 1944 hour 1 p.m. minute _____ M.

21. I hereby certify that I attended the deceased from 3-30 1944 to 3-31 1944

that I last saw h.l.m. alive on 3-31 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Paralyzing
Brain + Nerve centers

Due to Brain Hemorrhage

Due to High Blood Pressure + Old Age

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature A M Wiley (M. D. or other) 7 100
Address Puxico - Mo. Date signed 4/17/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

RECEIVED

District Health Office No. 2,

District File Number 544-735

Date Filed 5-11-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

Embalmed....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Hunter Albright

Licensed Embalmer No. 4210

P. O. Address Sikeston Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.